Reorganization of Medical Practice Its Influence on Patient-Physician Relationships

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No physician in the United States, no matter what he practices or where he practices, can help being aware of the powerful surge of change on the medical scene over the last few years. Never has there been more said and more written in the field of medical care than there has been over the last five years. Politicians, economists, insurance experts, hospital administrators, labor leaders, industrialists, educators and even patients and physicians have all had their say. The passage of Medicare has been followed by a series of three-letter health laws, the RMP, the OEO, the CEP, and the CMP. The physician has been repeatedly told that the passage of each new bill will have an even greater influence on the practice of medicine than its predecessor or any previous single piece of legislation. We neglect our patients while sitting in committee meetings designed to work out ways to ease the shortage of physicians. In spite of all this massive effort, the problem worsens, programs overlap programs, monetary bait captures a few but frightens many. The problem, simply stated, is that large numbers of people in this nation are economically, culturally and geographically isolated from good medical care. I define good medical care as physicians defined it in 1969. The patients would define this differently. Systems analysts and experts in cost benefit ratios would define good medical care in still different terms. All might be right with their own definition.

Every major change in science or art must be preceded by a change in philosophy. This philosophical shift in American medicine is really a very slight change from the philosophy long held by physicians. We have said that we will take care of anyone who requires our services regardless of race, color, creed or even economic status. This has been more recently restated that good medical care must be available to all citizens as a basic human right. This is, of course, not the same as the previous statement, but while intellectually we might have trouble accepting this, practically we cannot disagree. The real shift in philosophy, then, is that good medical care must be available to all citizens no matter who they are or where they live, whether in the hills of Appalachia, whether in the slums of New York or in the back lanes of Nanakuli. This, of course, changes the whole picture; no longer can I sit in my office on King Street in Honolulu and tell the world that I will take care of all who come to me. In reality, I had already stopped seeing all who sought my care because of state laws that make it possible for medically indigent patients to receive treatment at certain hospitals but not in my office. True enough, I might see the same patients at no charge during my stint in the hospital wards or clinics, but this is really not the same as a free choice on the part of the patient. But beyond this technicality it now becomes my responsibility yours and mine to see to it that all members of our community and our country are not denied medical care for any reason, even if that reason is the price of cab fare. This makes an entirely new game with a new set of rules. How do you get physicians and other health workers to move from group practice in a pleasant university town with good schools and other cultural advantages to a solo practice in a rundown office in a ghetto area with a high crime rate and poor schools? The need of a community for good medical care is a strong compelling force, but by itself is not enough. The answer, of course, is that medicine does not and cannot stand alone within a community. It must properly be considered as an integral part of the total community, its housing, its schools, its parks, its art and culture or a lack of these things within the community.

If the problem, then, is the isolation of the consumer from the product, the patient from the health services, and need has thus far not resulted in a solution, what then are the leverage points in solving the problem?

1. **Economics.**—Making available funds for medical care through private and governmental insurance and other sources may attract some physicians to areas with high needs for health services. Welded together about such economically based health services are such plans as the Health Insurance Plan of New York, Kaiser Plan, and others.

2. **Organization.**—The removal of some of the professional and cultural isolation of health workers, including physicians who would practice in high need communities, requires effective affiliation with other health workers in universities and clinics. The more complex organization of health services also requires a much higher level and supply of medical management personnel and techniques than are presently available.

3. **Education.**—This is probably the real key. Schools of health sciences must reorient teaching away from the almost exclusively organ-disease centered curriculum to a patient-society oriented curriculum. This is difficult because professors are no more eager to throw away their lecture notes devoted only to disorders of organs than physicians are to adopt new approaches to patient care. However, the students will soon insist that they do precisely this, just as patients will insist that physicians develop more effective systems of health service delivery.

What will be the organization of medicine then? First of all, the increase in group practice is inevitable. There are too many advantages to both physician and patients to have it otherwise. The group practice I am speaking of bears only a superficial resemblance to group practice as we know it, where physicians are practicing in much the same one-to-one manner as their grandfathers did. An effective group practice means more than the sharing of overhead, administration, accounting, and laboratory services, and more available consultation. It means a full realization of the potential of an outpatient-based comprehensive medical care system.

Second, the cost of medical care will be more broadly spread over groups of people and periods of time by prepayment capitation plans. I can see no real alternative to this either.

Third, there will appear shortly on the medical scene a new cadre of health workers, many as yet unnamed. Assistant physicians, diagnostic technicians, surgical technicians, and a whole series of aides are a few of the people who already are finding their way into areas of medicine with desperate need for these people.

With improvement in industrial design, automation, and increasing use of the computer, the technical aspects of medicine are made easier. The physician who insists on having a purely

technical relationship with patients runs a very high risk of being replaced by another less expensive technician or a machine. A physician who is functioning as a machine deserves to be replaced by one. A whole series of diagnostic and therapeutic procedures now done largely by physicians are beginning to be done by non-physicians. These range from a simple procedure such as taking the patient's temperature to more complex activities as interpreting EKGs, performing cardiac catheterizations or proctoscopic examinations.

Here in Kansas, Lewis and Resnik have already demonstrated that a nurse can manage the care of certain phases and aspects of chronic diseases better than physicians. Nurse-managed ambulatory clinics with patients receiving strong supportive therapy by the nurses apparently result in less disability from the chronic disease than similar clinics run by internists.

We, then, must think not only of patient-physician relationships but patient-machine relationships (or interfaces), patient-nurse relationships and patient-paramedical relationships. This whole matter of the patient-physician relationship is extremely important because in this relationship is defined the physician's role in our society.

There exists between patient and physician an unwritten contract that goes into effect when the patient asks the physician to take care of him. The physician, by applying a bandage or looking down the throat, indicates that he will. All of us know that this arrangement no longer holds in quite the same manner. When a patient asks such a question, whether expressed in words or not, the physician now replies, "It depends on whether or not your present or future illness matches my speciality or subspeciality." This relationship between patient and physician for several million people in the U.S. has been formalized by written contracts. Groups of physicians, through an insurance plan, agree to take care of certain specified diseases for a certain period of time for a prepaid fee.

The group assumes the responsibility once held by the individual. The "I" in the unwritten contract becomes replaced by the "We" in a written contract. The relationship then becomes a patient-organization one in which the organization, not the patient, decides who is to treat him. Patients often find that the technical aspects of health services are easier to organize into a system than are the professional or human aspects. They seek more and deserve more than technology.

There are other implications to this relationship which in its definition of the responsibility of a physician to a patient indicates a job description of the physician. The schools of medicine use such a job description of their faculty members as guides for admission of students to medical schools and around such job descriptions build their curricula. We therefore continue to create a large excess of physicians trained to care for horizontal patients in hospital beds.

In contrast, our education of physicians and other health workers to care for the one hundred ambulatory patients for every hospitalized one, is hopelessly inadequate. A few years ago perhaps the education of a physician as a junior scientist may have been defended on the grounds that we had to pound all of those facts into his head in a very short period of time. The human brain was regarded as a poorly designed structure incapable of storing all the medical facts appearing in the tons of medical journals published every year. We fragmented medicine into specialities and subspecialities largely because of what many regarded as a gross error in brain design. The truth is that the human brain is quite a remarkable structure, clever enough to provide its owner with books, and more recently computers, as storehouses of knowledge. The physician then is freed to function as a scientific humanist to creatively analyze the biological maladjustment responsible for his patient's disease. The physician must be prepared to combat the cause of disease whether it lies in his patient's environment, his society or within himself.

The physician of the near future must function as a technician and accept this role, or he must function as a true professional creating new health workers where needed and organizing about him the new people and technologies to improve the care of his patients. If there is thoughtful consideration of the patient as well as his disease, patients will accept these new interfaces and all participants, including the physician, will be the better for it.

Summary

Health Care in the United States: The Need for a New Paradigm

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American medicine, as practiced at the close of the 20th century, has some major problems that we categorize as being "upside down, inside out, and backward." Fortunately, these are correctable.

First, it is upside down. Primary care should be the foundation of the structure upon which the entire practice of medicine is built. However, it is not working that way. Specialists and subspecialists have become the wobbly foundation of health care in America. This makes our care system *upside down*, with the underpinning being procedure-oriented specialists who get only a glimpse of whole patients and their needs.

That is not the only problem. The system is also *inside out*. The key person in the entire system, and the whole reason for health care, is the patient. The patient has become lost within a very complex, disconnected system. The welfare of the patient should be the core that provides the energy that drives the system. Does it really work that way? Not quite. The patient, not necessarily his or her welfare, sometimes becomes the grist for the medical mill. The system is turned inside out.

And it is *backward*. But how can we believe the American health care system, which has made such enormous strides in the last century, can be called backward? There is no argument regarding the high peaks of achievement in both research and practice; but there are deep valleys with a persistent and increasing percentage of the U.S. population (with the exception of Hawaii) that has no health insurance coverage. In addition to 30-million people without health insurance, there is a worsening of many of our vital statistics. Infant mortality is increasing as is mortality from many preventable diseases such as lung cancer. Patients, their physicians, the government and insurance carriers are all dissatisfied with our system. Are we moving forward or backward? The figures indicate that in many areas we are slipping backward.